A. Louis Jimenez, DPM, PC
Primera Foot and Ankle Centers
Georgia Ambulatory Surgery Center

Perimeter	Snellville	Johns Creek	Surgery Center
1150 Hammond Drive	2220 Wisteria Drive	6610 McGinnis Ferry Rd	PO Box 527
Building E, Suite 520	Suite 202	Suite 200	2175 North Road
Atlanta, GA 30328	Snellville, GA 30078	Duluth, GA 30097	Snellville, GA 300788
678-395-3628 (phone)	770-979-0900 (phone)	770-497-1017 (phone)	678-514-0590 (phone)
678-691-5164 (fax)	770-979-2852 (fax)	770-497-1018 (fax)	678-514-3101 (fax)

*We require payment at the time of treatment unless other arrangements are made prior to your visit. We do not file with all insurance companies, only those carriers with which we are under contract. If surgery (over $500.00) is required, we will file for your insurance benefits, collecting deductibles and co-pays at the time of visit.

Our office also dispenses medical supplies necessary in your treatment and payment for these will be required at time of service.

I authorize release of all medical information necessary to process my insurance claims and is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to the above named physician or ambulatory surgery center. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. **There will be a $25 fee for a copy of your medical records or $30 for medical records plus CD or film**. *(this price may vary depending on # of pages, etc)*

I understand and agree that I will be responsible for any balances not covered by my insurance. In the event that my account balance becomes more than 45 days past due, I understand and agree that I will be assessed a monthly $10.00 late fee/rebilling fee.

In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (40%), attorney fees, court costs, etc.

Any NSF/returned checks will be assessed a $30.00 fee.

If it is necessary to cancel your appointment, please do so 24 hours prior to your appointment or your account may be assessed a $25.00 no-show fee.

I have read, understand and agree to the office policies stated above.

Print Name

Signature of Responsible Party

Date

Witness